
Pia: Greetings, and welcome to today's webinar on implants, the first of the Family Planning Methods series. My name is Pia Kochhar, and I'm the Knowledge Management Coordinator for the Advancing Partners and Communities Project. Before we begin today's presentation, I'd like to review the Adobe Environment, and set a few norms for today's webinar. Today's webinar has three presentations, followed by a discussion period, during which our speakers will address your questions. Within the webinar environment, please make use of the Q&A box on the bottom right side of your screen, to share your thoughts, note your questions, or ask for help with sound during the presentation.

Questions you ask are only visible to you, our presenters, and technical support. If you are experiencing difficulties, our technical support will respond to your question privately. We will collect your questions for our speakers, and will save them for the discussion period. It is great that we are able to connect people from so many places today, but your experience may vary, based on your internet connection, and computer equipment. I will briefly go over a few troubleshooting steps, if you have technology challenges today. A few troubleshooting tips: If you lose connectivity, or cannot hear, close the webinar. Re-enter the meeting room in a browser other than Google Chrome by clicking on the webinar link provided.

Use the Q&A box to ask APP tech for assistance. If troubleshooting steps are not successful, please rest assured, the webinar is being recorded, and you will receive an email with a link to the recording, following today's events. Questions that don't get answered during the Q&A sessions will be compiled after the webinar, shared with presenters, and responses from presenters will be shared with participants. To get us started, I will now turn it over to our moderator, Elaine Menotti.

Elaine: I would like to welcome, and thank everyone for joining us today. My name is Elaine Menotti, Health Development Officer for USAID. Today's webinar is organized by the Advancing Partners and Communities Project, in collaboration with Family Planning 2020, the Implementing Best Practices Initiative, and USAID's Office of Population and Reproductive Health. This webinar on implants is the first in a series of webinars, that will highlight a range of family planning methods, to deepen our understanding and expanding method choice, globally. We are aiming to reach Ministries of Health, policymakers, donors, and program managers. This series will provide information on family planning

methods themselves, country case studies from a range of partners and settings, and highlight family planning service delivery channels.

We are aiming to provide technical information updates, on a broad range of family planning methods, engaging a global audience, highlighting programmatic successes and challenges, and help answer questions specific to each method. And, while each webinar will highlight a single method, it's programs and in practice, we expect that clients have access to a broad range of methods, they receive client-centered counseling, they can freely choose their method, they receive detailed information on the chosen method, and that providers are able to offer, and counsel clients on a range of methods. After each presentation, we will have a quiz, to test your knowledge. I will go over the answers at the end of the webinar.

Please take a few moments to answer our first question. I would now like to introduce our first speaker. Dr. Abdulmumin Saad, of USAID's Office of Population and Reproductive Health. Over to you, Dr. Saad. Hi, Saad, are you there? Just wait a few minutes, while our presenter gets his audio connected, but we are ready when he is.

Dr. Saad: Hello, can you hear me?

Elaine: We can hear you.

Dr. Saad: Sorry, I was **[inaudible]** **[00:05:29]** Thank you, Elaine, and thank you Pierre and Sheila, for putting this together, for the logistic support. And, thank you for the opportunity to participate in this important webinar. I will be discussing, briefly, on implements, and we do know that implants were introduced almost eighty years ago, and they are one of the most effective forms in planning the **[inaudible]** that are presently appropriate kind of information. The population **[inaudible]** the first contraceptive implant, called Nexplanon, which was approved in 1983. But, I think Nexplanon **[inaudible]** Next slide, please?

The other thing, we'll look at what are implants, and making them function. Including how to use, the side effect profile, and medical eligibility criteria, such as effectiveness, and type, and differences between implants. I will also discuss briefly the requirements and models for target pregnancies. Next slide? Quickly, implants are hormone containing things, that cover one to two rods, and

sometimes capsules and each are about the size of a matchstick. And, they are containing the hormone called progesterin, and they're inserted under the skin in the arm, and therefore are not usually visible.

And, once inserted, implants do not require any action from the client, and the implants are known to be very effective in preventing pregnancy, and they are rapidly reversible. And, no delay [inaudible] [00:07:20] in fertility, once they are removed. And, that is why implants are considered to be long-acting, reversible contraceptive methods, but implants are not the only method in this class. IUDs, including hormonal and contraceptive IUDs are part of this class, but this webinar will not be discussing IUD. Maybe we'll discuss in subsequent webinars. And, once inserted, they're effective for three to five years. Quickly, looking at the mechanism of action, or how implants work. They actually achieve their contraceptive action by thickening cervical mucus, and by blocking them from making an egg.

And, they also suppress ovulation, preventing the release of the eggs from the ovaries. The hormonal use suppress ovulation, which would in theory, and they are effective immediately, in fact, in the first five to seven days of the entire cycle. And, they are also effective immediately, to end immediate post-partum or post-abortion period. Next slide? Um, the currently available implants on the market are three products. The first product I'll be discussing in this table is spinal implants, manufactured by Shanghai [inaudible] Pharmaceuticals, and available under the global brand name, called [inaudible] including implant, [inaudible]

Delivery plan consists of two flexible, cylindrical rods, each containing 75 milligrams of progesterone, known as LNG, and has a total of 150 LNG in the product. It is the [inaudible] lasts for three years, but the manufacturers are currently preparing to make a submission to the WHO for extended use for up to two years. This is a great thing, because [inaudible] if the data is sufficient to warrant extension for up to four years of use. It costs about \$7.82, about \$8, and costs [inaudible], about \$2.50, \$2.67. I will pause a little to talk about CYT as [inaudible], which is protection provided by contraceptive methods during a one-year period. It's usually based upon the volume of all contraceptives sold, or provided to clients free of charge during the period. It doesn't usually estimate actual use or impact, but basically, providing information about [inaudible], and also allowing programs to

compare – compare programs across countries, and across activities. Next product I'll be discussing is [Gygel](#), which is manufactured by Bayer.

And, it **[inaudible]** **[00:10:35]** in 2009, for a five-year duration of use. It has two flexible rods, similar to spinal implant, and each containing 75 milligrams, for a total of 150 milligrams. It is in fact, a disposable, separate **[inaudible]**, which is the applicator, and the average cost is something like \$8.50, and \$1.70 cost by CYT. Implanon NXT is manufactured by Merck. It consists of a preloaded, disposable applicator, that makes it much easier to provide and insert one flexible rod, which contains 8 milligrams of etnogestrel, also known as ETG, or lidocaine. It costs about \$8.50, and \$2.80, per CYT. It's important to see the differences in the molecule, between the three products. Both Nevoplan and Gygel contain etnogestrel, while Implanon NXT contains 6 milligrams of etnogestrel as the active ingredient.

And, it has only one rod, while the Nevoplan and Gygel has two rods of 75 milligram each of LNG. And then, quickly, just to highlight what the [bridge](#) of pre-qualification is. It is a service provided by the WHO, to assure the quality and safety, as well as the efficacy of the different products. Originally in 2001, the purpose was a medicine for treating HIV/AIDS, tuberculosis and malaria. But, in 2006, this was extended to cover medicines and products for reproductive health, including family planning products. Next slide, please?

In terms of the **[inaudible]** for family planning, extremely effective contraceptives that release an ultralow amount of progestin, continuously, into the bloodstream. Women who use implants found them to be very convenient, acceptable, and highly tolerable. And, implants do not interfere with sexual intercourse, **[inaudible]** fertility of the [response](#) area is not delayed, or negatively affected, once the implants are removed. And, they are suitable for all women to delay, space, or limit pregnancy, and they are becoming increasingly popular across the world. It is important to mention that implants do not protect against sexually transmitted infections, and HIV, and if that is a concern, it is recommended that whoever has an implant as the product of choice should use other methods of prevention, including condom use.

Next slide? These are some of the experiences that clients – experiences from clients who use implants. At the initial – immediately post-insertion, is usually the common symptom that

clients present with is infection and irritation. And, very rarely, infection at the site of implant [inaudible] [00:14:02], but we hardly see that routine in practice, but it does occur very rarely. And, the immediate side effect associated with the use of implants is change in bleeding pattern, related to frequency, duration and amount, which can result in irregular bleeding, spotting or heavy bleeding. And, in some cases, a rare cessation of the menstrual bleeding completely. And, other potential side effects include mild headaches, abdominal pain, nausea, breast tenderness, and mood changes.

Next slide? One great advantage of implants is that it can be used by almost all women, ranging from young individuals, who have barriers to use of different family planning methods, to [inaudible]. And, it's also available to women who want to space their births, either after giving birth, that is in the post-partum period, or immediately after an abortion. And, it also can be used by a woman during breastfeeding, and women who are HIV positive, and also can be used to limit birth outside of [inaudible]. Either a woman with high parity, or a woman with low parity. Next slide?

A little about the medical eligibility criteria, which is now on the street in a print edition, that is released in 2015, and the make is evidence-based information and guidance, developed by the WHO on the 15 various contraceptive methods for use in the context of specific health conditions and characteristics. It contains more than 2,000 recommendations for 25 different methods, and addresses more than 80 different medical conditions, or patient characteristics. Addressing issues from basic condition, to physiological state, as breastfeeding, or pregnancy, and it guides you through 48 classifications, that is stratified by safety for using the contraceptive method, given a specific condition.

And, these categories are: one, two, three and four. And, the first category are all conditions that do not have any restriction on the use of the method, or any method of contraceptive. And, in the second category, contains conditions where the advantages of using a method generally outweigh the [inaudible] risks of not using the method. And, theoretical – in the third category, it's going to be the theoretical risks generally outweigh the advantages of using the method. And, for category four, it is an unacceptable health risk to use the method. In [inaudible] where it is really difficult, or we do not have the infrastructure and the capacity to clearly differentiate condition into category one, two, three and

four, the WHO made it easier to collapse the two – the first and second category into one, single block, that the method can generally be used.

While, in category three and four, it's collapsed into one single block, that once a condition is in category three or four, that the WHO recommends that the method shouldn't be used in those conditions. Next slide? The good news is that implants – medical eligibility criteria for use in implants is usually within category one and two. If you look at the colored columns, on column three, highlighted in yellow, it's where implant belongs, and if you look at most of the conditions, they're either in category one, or **[inaudible]** **[00:18:05]** then the method could generally be used. And, the darker green color indicates category one, where the lighter green color indicates a category two.

But, there are some clarifications, and some other conditions, but generally, the good news is that implants are applicable, and could be used generally, for many of the medical conditions highlighted in medical eligibility criteria. **[Inaudible]** problems with clots, or unusual internal bleeding for women who have had breast cancer. Next slide? Looking at the typical effectiveness, implants, as I have mentioned earlier, that they are one of the most effective contraceptive methods available, with an unwanted pregnancy rate less than 1 percent with all implants, all the three products I have discussed in the previous slide. And, continuation rates are often better for long acting methods, including implants, than those for shorter-acting methods.

And, most admitted differences are found in the contraceptive effectiveness or continuation rate, among the various three classes, or three groups of implants discussed in the previous slide. Next slide? Implants, **[inaudible]** are discreet, with adequate infection control, privacy, constancy, and continuity of care. One important aspect of most actively reversible contraceptives, including implants, is that it's important that programs are planned **[inaudible]**, to ensure that the capacity and well-trained providers, and well-motivated providers are there, to provide the service. Including informed choice, thoughtful continuity, to help clients select the method, and **[inaudible]** regarding common side effects of implants, especially about bleeding changes, and they are capable in reassuring management of side effects, especially of issues related to bleeding changes.

And, regular and reliable access to removal services is very

important. Where there are no removal services, they may backlash, and have a negative consequence, [inaudible] [00:20:39] And, of course, adequate follow up and referral systems, where especially a woman receives implants, in a mobile platform, a mobile service in every channel. Next slide? A number of countries have successfully followed an innovative style of delivery model, that can be used for medicated supply providers. These providers focus primarily on delivery of undiluted clinical contraceptive methods, including implants. They also a wider range of other methods, besides. And, the service model is also typically [inaudible] and prohibition of these services, either free or public or private sector, for a fee. Or, through an outreach, or a voucher system.

[Inaudible] system, especially for women who receive implants from mobile services, or community based programs; it's really vital, [inaudible.] Next slide? [Inaudible] by stating that implants are very effective. They are treatable for nearly all women, with only one action, women who sometimes can be almost certain to have an unintended pregnancy for up to three to five years, and many kinds of different healthcare providers can provide implants safely and effectively. Some of the [inaudible] include quality is highly essential, and confident about our management of bleeding side effects, and keeping healthy women using implants successfully, in order to reduce discontinuation rates. And, [inaudible] is delivery intensive, but highly motivated and trained providers are [inaudible] woman. Because, if there is no provider, there would be no program.

And, if we have high upfront costs, the overall costs of implants, like CYT, is comparable, or even less than that of injectable alternatives. Thank you very much, and I look forward to responding to your questions.

Elaine: Thank you, Dr. Saad.

Megan: Morning, good afternoon, good evening, good day, good night, wherever you are. Thanks Elaine, for the introduction, and to Dr. Saad for the excellent overview to contraceptive implants. I think that's a great predecessor to what I'm hoping to talk about, which is addressing some of the global trends in contraceptive implant use. As well as a few programming considerations for implant introduction and scale up that we found particularly relevant, and helpful, in our family planning work, here at Jhpiego. So, first, let me go through some of the trends.

So, contraceptive implants are accelerating growth in contraceptive prevalence, worldwide. Avenir Health recently conducted an analysis of 256 DHS surveys, and when comparing the distribution of annual rates of MCPR growth, between countries with significant uptick of implants, and those without it, found that uptick of implants was associated with higher rates of MCPR growth. They also found that the growth of implant use was not coming at the expense of use of other contraceptives. In other words, that implants were not cannibalizing, or being substituted in place of other methods. So, they also noted, actually, that with every 1 percentage point in implant use rise, there was an associated 1 percentage point rise in MCPR, implying that the rise in implants is not dominated by modern method users switching methods. But, rather, a net growth in modern users.

So, I think, really promising to think about the power that contraceptive implants have in raising overall MCPR, and meeting the needs of women and families around the world. So, next, I just want to turn to a few country-specific examples of MCPR, and implant growth. So, first, I'll start with Kenya. I'm gonna give you a quick orientation to the slide itself. Because in each of the three country examples I'll show, I'll be using the same template. So, what you're looking at right now is, overall contraceptive prevalence, represented in the total height of each bar, with the colored sections within each bar, representing the method mix that constitutes that prevalence.

So, in each case, contraceptive implants will be represented in that pink, or purplish color, and I'll leave the Y-axis on the same scale, so that it's easier to see the relative composition of contraceptive prevalence, and method mix, across the three countries. On the X-axis, across the bottom, are the DHS and PMA surveys, from which this data was pulled, and the year they were conducted. So, you can see, over time, how MCPR, and implant method mix has shifted. So, here in the Kenya example, you can see that MCPR has grown quite impressively, over the past few years, to over 60 percent of married women, using modern contraception. With implants making up over 25 percent of the method mix. You can see how that dark, pink section really grows over time. Of note, implant use, also, is relatively high, among unmarried women, which are not represented here on the graph, at around 11 percent of the method mix.

So, turning to another East African country, here we have Uganda.

Uganda has lower contraceptive prevalence overall, but again, you can see that the contraceptive implant proportions are increasing over the past few years. And then, in a third context, this time, Burkina Faso, in West Africa, here, we also see recent rises in total contraceptive prevalence, again, in the total height of the bar. But, the contribution of implants is even more drastic in Burkina Faso, with implants now making up nearly 50 percent of the method mix, among married women. So, a really substantial share of contraceptive use coming from contraceptive implants in Burkina. So, those are just a few country-specific examples of the contribution that implants make to MCPH growth in some settings.

But, obviously, implant use varies greatly around the world. So, where do implants comprise larger proportions of overall contraceptive use? Well, this map shows the proportion of implant users among all married contraceptive users across a number of countries. This would be otherwise known as implant's contribution to the contraceptive method mix. So, in the darkest green countries on the map, the contraceptive implants comprise over 15 percent of total modern contraceptive use. So, as you can see, Burkina Faso, Kenya and Uganda, are all represented in dark green, to reflect the large proportion of contraceptive use, attributable to contraceptive implant use, which was mentioned in the previous slides. Looking outside of the African context, you can also see for example, that Indonesia, on the right side of the screen, is more of a medium green.

They have about an 8 percent method mix, attributable to implants. So, just a nice, kind of global picture of where implants comprise a larger proportion of contraceptive use. So, what's led to the accelerated growth in contraceptive implant use in recent years? Well, for one, in 2012, a price reduction was negotiated with two major contraceptive implant manufacturers, Bayer and Merck MSD, to reduce the cost of implants to \$8.50 per unit, down from around \$20 or \$25, just a few years prior, as you can see here on the slide. This created price parity among the three major implant manufacturers, including Shanghai Dai Lo, whose product, Levoplant was already competitively priced.

The reduced price of implants allows for larger procurements from countries and donors, and improves their accessibility overall. Now, taking a closer look at the users of contraceptive implants, here's some data about how implant users compare to contraceptive users overall. So, this data is from special surveys, conducted by PMA 2020, in Burkina Faso, Ethiopia and Kenya.

And, in these countries, implant users are, on average, more married, higher parity, and less educated than the total population of contraceptive users in those countries. They're also more likely to receive their method in a public facility. So, for example, just looking at Burkina Faso, we see that, overall, 85 percent of contraceptive users are married. But, for implant users alone, that figure is 90 percent.

74 percent of contraceptive users in Burkina have at least two children, while 80 percent of implant users have at least two children. And, while 56 percent of contraceptive users have no education, 64 percent of implant users have no education. Additionally, from the analysis by Avenir Health that I referenced earlier, they explored whether implant use was concentrated in certain age groups, and found that no implant – that no, implant use occurs across all age groups, globally. However, I'd be remiss not to mention that more exploration is needed, to understand a little more how we can improve accessibility to all family planning, including implants, to adolescents and youth. Okay, so now, we'll shift gears a little bit, into some programming considerations, for introducing and scaling up contraceptive implants.

Before moving into the considerations, themselves, I'd like to make an important point, which I think Elaine mentioned earlier in the webinar, as well. That contraceptive implant programming is rarely done as a standalone effort. Rather, efforts to improve access to contraceptive implants and generally best seated in programming that seeks to improve access to a wide array of contraceptive options, so that clients can make an informed choice. I thought I'd first share some lessons learned from a multi-country project, led by Jhpiego from 2013 to 2016, under the Bill and Melinda Gates Foundation funded Accelerating Scale of Implants project, Jhpiego worked with stakeholders in Kenya, Nigeria, Zambia and South Africa, to capacitate healthcare providers and systems to respond to the growing availability of, and demand for contraceptive implants.

In that context of full method choice. I delve a bit deeper into a few of these on the following slides, but overall, we learned it was critical to develop implant introduction and scale up plans. To factor in product evolutions. To consider the needs of implant users, not only at initiation, but also for follow up care and removal. To consider the provision of implants outside of family planning wards, for example, through community based

distribution, or in maternity settings, for postpartum clients. To avail the necessary equipment and consumables, that are required to insert and remove contraceptive implants. And, to work with communities and clients to dispel myths and misconceptions.

So, now, just to highlight a few of these specific lessons. I noted on the last slide that it's important to factor in product evolutions in scale up planning. And, what I mean by that is, that programs should understand which implant products they have, or will have available in their contraceptive market. So, Implanon NXT, for example, is a new iteration of the classic Implanon product. It utilizes an improved insertion device, or trocar, which operates slightly differently than the earlier version. So, introducing Implanon NXT, in contexts where providers were familiar with the previous version of Implanon, requires refresher courses for healthcare providers. And, I think this is an important lesson learned out of some of our work.

So, the resource noted on the slide here, is a – for a course to quickly and effectively update implant providers on this newer Implanon NXT device, through on the job training. Dr. Saad, in his overview, also highlighted the recent WHO prequalification of Levoplant. Well, over 200,000 Levoplant have been procured in recent weeks, to Sierra Leone, Uganda and Malawi. And so, programs expanding access to Levoplant should ensure that healthcare providers are adequately trained to offer two rod implants, again, noting that the insertion mechanism for a two-rod implant versus a one rod implant is slightly different. And so, having providers trained in one and not the other requires that they be updated in both, if they're expected to offer both.

So, the next lesson that I wanted to highlight was that programs should consider the needs of implant users, not only at initiation, but for follow up care and removal, as well. Here, we have a simple graphic, developed by the Implant Removal Task Force, and the graphic demonstrates the conditions that should be in place, in order for a client, using a contraceptive implant to be assured access to quality implant removal services. So, for example, implant clients should know where and when they can get their implant removed, and those services should be available when she wants them, and within a reasonable distance. At the time of removal, she should be offered reassurance, and counseling, reinsertion, and the option to switch, or discontinue a method, if she would like.

A confident and competent provider should be available, and the supplies and equipment should be in place for the procedure. It's also important to note that the service should probably be affordable, or free, and that the data around implant removal should be collected, and monitored, and used to inform programming in the future. It's critical that any programs that strive to improve access to contraceptive implants, also improve access to follow up care, and removal when desired. This is also responsive to the principles of rights-based family planning. So, next, when it comes to availing implants immediately after delivery, Dr. Saad noted that women are medically eligible to use contraceptive implants immediately after delivery, even when breastfeeding.

This is also shown in the postpartum contraception initiation timing graphic, shown here on the slide. With that in mind, programs should consider how maternal care settings, including ANC, intrapartum, and post-natal care, can adequately counsel for and provide implant services. So, this may require training additional providers, from maternity wards, to offer implants. And, stocking implant commodities and supplies in the labor and delivery ward, to facilitate more efficient provision. It may also require strengthening internal facility referral mechanisms, so that women can pass by the family planning ward, during their childbirth stay.

The final lesson learned that I'll address during today's webinar, is the need to avail necessary equipment and consumables to insert and remove contraceptive implants. It's not enough to ensure that the implants themselves make their way down to facility stockroom shelves. Contraceptive implant insertion and removal require a few basic instruments, and consumables, to be carried out safely, and with quality. On the side here are all of the required equipment and consumables necessary for implant insertion and removal. Note, the forceps are only needed for removal. So, these – we have job aids, like the one from which these illustrations were pulled and other materials to support LARC capacity building, and those can be found in the new Providing LARCs Learning Resource Package, available on [keferhof](#).

One final thing, before I hand this back over to Elaine. I just wanted to quickly address a final programming consideration, that might be on the horizon, which is a possible change in the approved duration of use, for the one rod contraceptive implant product, Implanon. Study findings published in 2016, and 2017,

demonstrated that the three-year Implanon product can actually provide contraceptive protection for up to five years, rather than the three that it's labeled for. So, I know we're really eager to hear if guidance will be issued on this duration change, and hope that you'll also stay tuned for more information on this. Certainly, a change in duration would require communication to providers and clients alike. Of note, Dr. Saad also noted that Levoplant's labeling, under WHO pre-qualification, is also likely to shift from three years to four years duration of use.

Elaine: Thank you, Megan. Please continue adding your questions for Megan in the Q&A box, and next, take a few moments to answer our next quiz question. The next presentation is from George Akanlu, of Mary Stokes International, Ghana. Over to you, George.

George: Hi, good afternoon, good morning to everybody. I hope you can all hear –

Elaine: We can hear you, George.

George: Okay. So, I just want to start by saying thank you to the organizers for making me a part of this webinar, and also to the two previous presenters, for laying the background. I'll start by giving you some context of the Ghana program. So, if you look at Ghana, we have limited access to the full range of family planning services, and this is more prominent in rural areas, because they are limited too, out there for the provision of long acting and reversible family planning methods. There are also gaps sometimes, in commodity availability, at the facility level. Not because the commodities are not available, but because the problem is in supply chain management.

That it goes this way, the commodities are stuck either at the regional level, or at the district level, and not getting to the facilities, where they are needed. And, family planning is still not free in Ghana, and therefore, cost is still a barrier. So, if we look at uptick of family planning generally, and a similar proportion of contraception in rural and urban areas. But there are huge barriers to regionally, this is [inaudible] [00:40:17]. But, if you look at [inaudible] the variation between uptick in rural areas and in urban areas. And, if you look at the service [make, last PM](#), constitutes just about 20 percent of the total uptick in Ghana. And, for implants, they are the preferred one, and Gygel is the most preferred implant.

For us, and my resource specifically, we provide family planning services to our client through different channels. So, we currently have nine centers of XMN, which sets the standards for service delivery in our country program. And, these centers are strategically located, and we ensure that the right atmosphere is created in these centers, so that our clients feel at ease, and comfortable. We also have a network of Blue South Ability, this is a network of 12 quality-assured private providers, who provide voluntary family planning services across the country. And, the 180 facilities are located in various urban areas, across the country.

We also have a network of [inaudible] [00:41:56] which are individual midwives, nurses or community health workers, who are self-employed providers. Who are trained by Mary Stokes, and certified to provide voluntary family planning services in their communities. We have the mobile team, we have eight mobile clinical outreach and in reach teams, and then, two public sector strengthening teams. The outreach teams focus mainly in the rural and hard to reach areas, getting voluntary family planning services to the doorsteps of our clients. The in-reach teams focus mainly on setting target groups in urban slums, where access to voluntary family planning services is limited.

Now, the two public sector strengthening teams focus more on building capacity for the provision of low action and permanent family planning methods in the public sector. So, they take public sector workers to the whole range of information sharing, service provision, and quality assurance. We also have a call center, which is dedicated to providing services and referrals to our clients. So, for the tactics side, we have GPSs of all these separate sites, sitting with workers in the call centers. So, that any client of the call center, in any part of the country, that wants family planning services can be directed to any of the static clinics, or blue star facilities, where they can access care.

So, [inaudible] with a clinical pharmacy, and just as the previous presenters mentioned, Mary Stokes ensures that we recruit, train and competently assess all the providers who work in all these service delivery channels. So, providers are assessed, and whether they are competent or not, they are taken through a process where they become proficient and competent in providing the services. We also ensure that all these providers have access to the clinical guidelines. Guidelines by the local ministry of health, and international guidelines, within which they provide services. We

have a clinical quality team, in house, that looks at these service delivery channels on a quarterly basis, to provide support to them.

In addition to that, we have annual internal and external quality assurance audits. Internal, which means we get somebody in another Mary Stokes country, who comes in to quality assure our services. And then, external, we get somebody who is external to Mary Stokes, to come in and quality assure the services that we provide, through these service delivery channel. And, when gaps are identified, service providers are taken through administrative equipment that provides that, so that they're able to provide high quality services to our clients. We also ensure that incidents are reported, and managed through our systems within the Mary Stokes organization. So, we have a system where, when an incident happens in any of these service delivery channels, the team is put together.

They do the management, they investigate, they share the results among the other service delivery channels, as many, so that mistakes that are committed in certain channels are not repeated in others. So, looking at primary implants programming generally, Mary Stokes Ghana controls almost 17 percent of the voluntary family planning market in Ghana. And, for LAPM, low action and permanent methods, we control nearly half. And, Gysel and Implanon are the most common family planning implants that we have in Ghana. Up until 2015, implant services were only provided by midwives. But, thanks to some work that has been done by Mary Stokes Ghana, the Ministry of Health, and other partners, the Ghana Health Service has now approved that trained and certified Ministry of Health workers can now provide implants.

And, Mary Stokes played a key role in bringing these community health workers, and training them so they can provide implant services. Just some of the key things that we do in reaching out to our clients. So, I look at this grouping of service delivery channels into two, looking at the static side, and the mobile side. And, for the static side, family planning awareness raising activities are carried out, basically we're seeing satisfied clients in those community, coming together in a gathering of opinion leaders and community members, and service providers, where the service providers have an opportunity to provide information and education to community members, on various family planning methods.

We also worked with the Ghana Health Service, where promoters

within the Ghana Health Service work with our community based volunteers, to do door-to-door consultations, do door to door discussions with clients, and where there's a need for it, send out their **[inaudible]** **[00:48:10]** to the service delivery channels for services. We also have what we call the service referral system, because if you look at the network of our blue star facilities, there are 130 of them. Not all of them provide the full range of family planning services. So, for instance, most of the implant services are provided across all of the facilities, but if you look at the other LATMs, like vasectomies, and **[inaudible]** topic we're discussing here, are not services that are provided across all of the facilities.

So, when a client comes in, and wants some of these services, that are not provided by any of these facilities, they are referred to others within the network, where the service is available. And, again, as I indicated, we have a call center, which offers an anonymous platform for client engagement and referral. And, we usually have very good branding in our static facilities, our blue star facilities. And, our clinics. For the mobile teams, we work basically through the public sector. So, our outreach team, and the capacity building teams, work through the public sector. So, in any district where they go to provide services, they work with providers within the public sector, and, we use community mobilizers, who work in the public sector, to go into the communities, and mobilize clients for our outreach teams, before the day of the service provision.

[Inaudible], they are stationed in the communities where it's safe, and therefore, they interact with the communities and people, when the clinic comes to them for family planning services. And, appealing all this is the quality assurance monitoring, that we do on a quarterly basis, and then, on an annual basis. And, in new communities, where our outreach and in reach teams visit, they also sometimes do targeted mass media campaigns.

Elaine: Hi, George, are you still there?

George: Hello?

Elaine: Hi, George, you're back on.

George: Yeah, sorry, I went off for a bit.

Elaine: That's okay.

George:

So, I was just trying to explain the uptick of family planning methods across all the channels. As you can see, implants constitute a greater part of the service mix, and the uptake of implant services have been growing year by year, from 2011 right to 2016. The data for 2017 is as of August, this year. And, as you can see, we are projecting that we will be able to provide more – provide implant services more than we did last year. So, you can see a progressive increase in the uptick of implant services, right from 2011. My previous presenters also talked about removal. So, this is also the rates of removal across all these channels, and as you can see, its highest among the static side. And, especially in our centers.

That has been dropping right from 2014. And I must emphasize that most of these removals are Gysel removals. And, the commonest reason usually given is the changes in menstrual cycle. The few instances where family members, or people who are ready to have children also come in for removals, but most people cite changes in menstrual cycle as the main reason for the removal. In terms of our clients, and provider insight. I must mention that we have a very robust system for getting our clients and provider insight for our static side. So, our centers and research facility. We do for the mobile teams, but not as rigorous as we do for the static side.

So, for our clients, implants, they feel it's less invasive, and they prefer it, compared to IUD, and they said that it's no or less pain in the implant insertion. And, Gysel is the most preferred, because it's offered them longer years of protection. And, most of our clients are happy to go to our mobile sites to access implant services, because it's for free, compared to going to any of the public facilities, or static sites., For our providers, they prefer Implanon, because it's easy to insert, as a result of it having a single rod. Providers also indicate that they're most proficient in implant insertion, compared to IUDs. And, most providers are trained in implant insertion, compared to IUD for instance, because as I indicated earlier, we now have nurse aides, and community health nurses, who can be trained to provide implants.

Specifically, to our program here. Generally, there's no uptick of LAT in Ghana, and this affects implants also. And, the key reason, usually, is about the misconceptions. So, for instance, a huge misconception out there is that implants cause infertility, causes fibroid, because of the changes in menstrual cycles, and so on, and so forth. And, there's a lot of work going on, in the community, to

dispel some of these misconceptions and myths.

And, also, volunteer family planning services are not included in our national health insurance system benefits package. Which means that people who walk into static sites would have to pay for family planning services. And this, again, is a barrier to uptick of family planning, especially for implants. For us, we still have, we think that the risk of removal is quite high. Especially in our centers, and some work is currently ongoing to understand – even though from the clients' insights, some reasons have been given for the removals, but some scientific work is currently ongoing, to get our [inaudible] [00:55:45] to find out exactly why there's such high removal in some of our service delivery channels.

So, this is what I wanted to share with you in brief, with regards to implant programming in Mary Stokes Ghana. Thank you very much, I'll take any questions that come up.

Elaine: Thank you, George. To our audience, please take a moment to answer question – our final quiz question, and we'll go over the answers, and move quickly to a few questions, in our remaining few minutes. Great, very quickly, so. In the introductory presentation, we asked, in a quality family planning program, we expect that clients receive client-centered counseling on a range of methods, and they can freely choose their method, without coercion. Our next presentation, Megan spoke about; introduction into country programs has caused a decrease in the use of other contraceptive methods, true or false?

Megan: And, I think just quickly, Ethiopia probably comes to mind as the place where that's been done at the largest scale and most successfully, although, countries like Nigeria are also doing community based provision of implants through their health extension worker contract. I think some of the keys to success, a lot of this has been led under a pathfinder bilateral in Ethiopia, but is around really deliberate training, and intentional, strategic introduction of implants in that context. So, requiring lots of training, and a lot of quality checks, to make sure that it's done safely. I would just make a note though, that I think one of the really important things, when we consider community-based distribution of implants, is just thinking about, what does that mean for removal, like I mentioned earlier.

So, if those are provided at the community level, how does that woman then get it removed? Does she go to the facility, does she

somehow queue up that health extension worker to come back to her? What does that look like? So, [silence] [00:58:30-00:59:09]

Elaine: And, George, would you like to add in? I know Ghana has worked with community health nurses, which are not extension workers, like in Nigeria or Ethiopia, but a community based provider. Did you wanna speak to Ghana's experience?

George: So, in Ghana, the community health nurses are usually located in the lowest level of service delivery. So, they are usually situated in the Chief's compound, which are smaller, single-room facilities, at a community level. And, at that level, they're allowed to provide implants. They work very closely with the community workers at that level, the community workers go into the communities to do the mobilization, to do education. And then, where people want services, they are referred then to go to the Chief's compound, where the services are provided to them. I think that's just the linkage between the community health nurses, and the community workers, at the community level.

Elaine: Thank you, George. We have time for one more question, and I will direct it to Dr. Saad. This question is from Jeremiah Yem. Is there any medical explanation to women on implants that tend to lose weight? And, as a second part of that question, he asks, is there any reason why Levoplant coverage is three years, considering the fact that it has the same composition and strength of Leven or Gestrel which – Dr. Saad? He may be on mute.

Saad: Yeah, I was on mute. Quickly, on the weight and implant use, I think there is no evidence for LNG – substantial evidence for both implants, the LNG and ETG for obesity, and reduced effectiveness of the method, according to medical eligibility criteria. Both methods are still medical eligibility criteria 1. But, there are some data that showed weight, and reduced effectiveness of implants, [inaudible] [01:01:36] use, but that has not been reflected in the medical eligibility criteria. Now, for the pre-qualification for three years, I think it's based on the data submitted to the WHO, and the [inaudible] detail from the manufacturers, that were in pre-qualification.

But, they are currently having new data, that may extend the use of the product for four years, and potentially five years, in the near future,

Elaine: Thank you, Dr. Saad. So, it's time to wrap up, and we will answer

the remaining questions that came in through the Q&A box, and we'll share those after the fact. We would like to thank all of the presenters for giving their time and expertise today, and all of the participants for joining us. In the next few days, you'll be receiving an email –

[End of Audio]

Duration: 63 minutes.